MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Pharmacy

November 2005 • Bulletin 618

Contents

New Web-Based Attachment Options for Pharmacy eTARs

All Pharmacy providers now have the option to print the *Treatment Authorization Request – Attachment Form* (TAR 3) directly from the Medi-Cal Web site eTAR NCPDP v. 5.1 application. The system has been upgraded to automatically populate the submitter's provider number, TAR control number and recipient's Medi-Cal identification number for providers who are submitting attachments via facsimile.

Note: The print option is only available when selecting the attachment submission option "I will be faxing attachment(s) within 1 hour."

Multiple Attachment Uploading Option

Pharmacy providers now also have the option to upload multiple attachments directly to an eTAR. Up to 10 separate attachments can be uploaded to a single eTAR in one easy session.

For complete instructions on accessing, printing and submitting the attachment form or uploading multiple attachments, view the online Pharmacy tutorial available on the Medi-Cal Web site (**www.medi-cal.ca.gov**). To access the tutorial, click the "eTAR Pharmacy Attachments" link in the "What's New" area of the home page.

CMC Claim Submission for Medicare/Medi-Cal Crossover Billers

Medi-Cal can now receive electronic crossover claims directly from approved submitters via the ASC X12N 837 v.4010A1 transaction. Submitters using the 837 format must include Medicare payment information at the detail/claim line level. Additionally, Medi-Cal can receive electronic crossover claims automatically from Mutual of Omaha and United Government Services Medicare intermediaries for most Part B services billed to Part A intermediaries. This new provision primarily affects outpatient and dialysis providers who were previously required to bill these claims on paper. Providers of Part B services billed to Part A intermediaries other than Mutual of Omaha and United Government Services must continue to bill their claims directly to Medi-Cal either on paper or in the new HIPAA standard 837 electronic transaction until a new automatic crossover process is established with the Medicare Consolidated Coordination of Benefits Contractor sometime in 2006.

Please see **CMC Claim Submission**, *page 2*

CMC Claim Submission *(continued)*

In order to comply with HIPAA electronic standards, providers billing crossover claims on paper for Part B Services billed to Part A intermediaries will be required to attach the detail/claim line level *National Standard Intermediary Remittance Advice* (Medicare RA) to a *UB-92 Claim Form* and comply with revised billing instructions. Any claims received after October 24, 2005 that do not comply with the new billing and attachment requirements will be returned to providers for correction before processing.

Providers may obtain detailed Medicare RAs by printing the "Single Claim" report, which can be accessed through the latest version of PC Print software, available free of charge. PC Print software and instructions are available on the United Government Services Web site (**www.ugsmedicare.com**) by clicking "Provider," then "EDI" and then the "PC Print Software" link. Providers should obtain the PC Print software from Medicare as soon as possible to ensure they can print the appropriate Medicare RAs.

Pharmacy Crossover Claims

Medi-Cal also now accepts Medicare Part B Pharmacy crossover claims for drugs in the HIPAA-mandated NCPDP 1.1 batch format. As a result, retail pharmacy providers or submitters who are billing Medicare using the NCPDP format will be able to stop billing the Medi-Cal portion of their crossover claims via the *HCFA 1500* paper claim form using HCPCS codes. These claims should cross over automatically from CIGNA Medicare. NCPDP claims that do not cross over automatically must be billed to Medi-Cal using the *Pharmacy Claim Form* (30-1) or the *Compound Drug Pharmacy Claim Form* (30-4) in order to accommodate the National Drug Codes (NDCs).

Providers or submitters who have not yet converted to the NCPDP 1.1 format with Medicare must continue billing the Medi-Cal portion of crossover claims that fail to cross over automatically with the *HCFA 1500* paper claim form using HCPCS codes (not NDCs).

For new crossover claim billing instructions and examples, please refer to the *Medicare/Medi-Cal Crossover Claims: Pharmacy Services* section of the *Pharmacy* manual.

Standing Systems and Standing Frames

Standers and standing frames to allow wheelchair dependent patients to achieve a passive standing position are Medi-Cal benefits subject to prior authorization. The equipment is billed with HCPCS codes E0637 (combination sit to stand system, any size, with seat lift, with or without wheels) or E0638 (standing frame system, any size with or without wheels).

Medical Necessity

Standers and standing frames are considered medically necessary when there is documentation of the following:

- The device would allow the recipient to become more independent in one or more of the activities of daily living, and
- For a recipient with a pressure sore, the device would provide pressure relief/off-loading of the pressure sore that cannot be accomplished by other means, or
- Lower body strength is increased by maintaining a standing position for recipients with spastic quadriplegia or other neuromuscular conditions who are unable to rise from a seated to standing position without assistance and have some residual strength in the hips or legs, or
- Lower body strength is increased by maintaining a standing position for recipients with paraplegia and other neuromuscular conditions who are unable to rise from a seated to a standing position without assistance and have some residual strength in the hips or legs, and
- There is documentation that the recipient has tried the system through an ongoing outpatient therapy program and the physical therapist has witnessed the use of the system and recommends it.

Please see **Standing Systems**, *page 3*

Standing Systems *(continued)*

Standers and standing frames are not considered medically necessary for recipients with complete paralysis of the hips and legs, such that lower body range of motion is not improved or maintained by the standing position, or if using the stander/frame would create an unsafe situation for the recipient.

Prescribing Physician
When ordering standing equipment billed with codes E0637 or E0638, the prescribing physician must provide medical documentation that the recipient has had sufficient training with the system and does not have a fracture risk or does not develop vertigo or become nauseous by standing. The prescribing physician must also document that the recipient is willing and able to stand and that there are suitable facilities and assistance available (when needed) in the recipient's home for standing.

TAR Requirements
Prior authorization (*Treatment Authorization Request*) may be approved only for those recipients who have had an adequate case management assessment of their overall needs for ambulation, positional changes and other essential activities of daily living, including an onsite evaluation as necessary.

TARs requesting authorization of HCPCS codes E0637 or E0638 must include the following information.

- Diagnosis, age, height and weight, or other information regarding size
- Description of functions (sitting ability, standing ability, mobility)
- Description of transfers, functional goals, current program directed toward functional goals
- Daily activities, relevant impairment (range of motion, bowel/bladder/intestinal function, history of fractures or risk for bone density issues, respiratory status).

Additionally, the TAR must provide answers to the following questions answered by providers for review by Medi-Cal TAR field office personnel.

- What is the recipient's history of standing or efforts to stand?
- What is the recipient's current standing program? Does the recipient stand in any other setting (school, work setting, etc.)?
- Is the recipient able to stand by any method other than a stander (against furniture, with assist of caregiver, with a strap or support, with a walker, etc.)?
- How is the use of a stander related to the functional goals for this recipient?
- What specific activities for this recipient require a stander?
- Is there a home program or therapy program that requires regular use of a stander?
- Has this recipient experienced a trial of the proposed stander or any other stander and what were the results?
- What other standing devices were considered, and why were they rejected?
- What other less costly alternatives were considered, and why were they rejected (other approaches to identified needs – range of motion, stretching, splints, respiratory activities, other methods of weight-bearing, etc.)?

Rental Trial Period
A three-month rental period is mandatory before purchase of any stander/standing frame unless the beneficiary has participated in a community program of standing three to four times per week, for at least three months.

This information is reflected on manual replacement page dura bil dme 19 (Part 2).

2006 ICD-9-CM Diagnosis Code Updates

The following diagnosis code additions, inactivations and revisions are effective for claims with dates of service on or after January 1, 2006. Providers may refer to the *2006 International Classification of Diseases, 9th Revision, Clinical Modifications, 6th Edition* for ICD-9 code descriptions.

Additions

259.50	276.50	276.51	276.52	278.02	287.30	287.31
287.32	287.33	287.39	291.82	292.85	327.00	327.01
327.02	327.09	327.10	327.11	327.12	327.13	327.14
327.15	327.19	327.20	327.21	327.22	327.23	327.24
327.25	327.26	327.27	327.29	327.30	327.31	327.32
327.33	327.34	327.35	327.36	327.37	327.39	327.40
327.41	327.42	327.43	327.44	327.49	327.51	327.52
327.53	327.59	327.8	362.03	362.04	362.05	362.06
362.07	426.82	443.82	525.40	525.41	525.42	525.43
525.44	525.50	525.51	525.52	525.53	525.54	567.21
567.22	567.23	567.29	567.31	567.38	567.39	567.81
567.82	567.89	585.1	585.2	585.3	585.4	585.5
585.6	585.9	599.60	599.69	651.70	651.71	651.73
760.77	760.78	763.84*****	770.10*****	770.11*****	770.12*****	770.13*****
770.14*****	770.15*****	770.16*****	770.17*****	770.18*****	770.85*****	770.86*****
779.84*****	780.95	799.01	799.02	996.40	996.41	996.42
996.43	996.44	996.45	996.46	996.47	996.49	V12.42
V12.60	V12.61	V12.69	V13.02	V13.03	V15.88	V17.81
V17.89	V18.9	V26.31	V26.32	V26.33	V46.13	V46.14
V49.84	V58.11	V58.12	V59.70**§**	V59.71****§**	V59.72****§**	V59.73†**§**
V59.74†**§**	V62.84	V64.00	V64.01	V64.02	V64.03	V64.04
V64.05	V64.06	V64.07	V64.08	V64.09	V69.5	V72.42**§**
V72.86	V85.0††	V85.1††	V85.21††	V85.22††	V85.23††	V85.24††
V85.25††	V85.30††	V85.31††	V85.32††	V85.33††	V85.34††	V85.35††
V85.36††	V85.37††	V85.38††	V85.39††	V85.4††		

Restrictions

***** Restricted to ages 0 thru 1 year
****** Restricted to ages 10 thru 35 years
† Restricted to ages 35 thru 55 years
†† Restricted to ages 18 thru 99 years
§ Restricted to females only

Inactive Codes

Effective for dates of service on or after January 1, 2006, the following ICD-9 diagnosis codes are no longer reimbursable:

276.5, 287.3, 567.2, 567.8, 585, 599.6, 770.1, 799.0, 996.4, V12.6, V17.8, V26.3, V58.1, V64.0

Code Description Revisions

The descriptions of the following ICD-9 diagnosis codes are revised:

285.21, 307.45, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93, 728.87, 780.51, 780.52, 780.53, 780.54, 780.55, 780.57, 780.58

All manual replacement pages reflecting these ICD-9 code updates will be included in future *Medi-Cal Updates*.

Family Planning Methods Discontinued

Effective immediately the following Family PACT (Planning, Access, Care and Treatment) benefits are discontinued.

HCPCS Code	Description
X1512	Intrauterine device (IUD) (generic code)
X1514	Progestasert intrauterine device
X1520	Levonorgestrel contraceptive implant (Norplant)
X7490	Medroxyprogesterone acetate and estradiol cypionate (Lunelle)
X7720	Levonorgestrel/ethinyl estradiol/pregnancy kit (Preven)

These family planning methods are no longer available for purchase in the United States. The generic IUD has been replaced by specific codes for currently available intrauterine devices. Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, providers may call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

New Sterilization Consent Form for Family PACT Providers Coming Soon

Begin using the PM 330 now for sterilizations scheduled on or after February 1, 2006.

Effective for dates of service on or after February 1, 2006, claims submitted by Family PACT providers for elective sterilizations (CPT-4 codes 55250, 58600, 58615, 58670, 58671, 00851 or 00921) must adhere to all Medi-Cal policies described in the *Sterilization* section of the Part 2 provider manual, including submission of a Department of Health Services sterilization *Consent Form* (PM 330). Use of the PM 330 also includes the following policy updates:

- Recipients must be a minimum of 21 years of age.
- A minimum 30-day waiting period between the recipient's consent and the date of the sterilization procedure is required.

Claims for elective sterilization from Family PACT providers for dates of service prior to February 1, 2006 must continue to follow current Family PACT policy as applied to the sterilization *Consent Form* (PM 284).

Revised *Family PACT Policies, Procedures and Billing instructions* (PPBI) will be issued in a future *Updated Information*. For more information regarding Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555.

Inpatient Provider Cutoff Date for Proprietary and Non-HIPAA Standard Electronic Claim Formats: December 1, 2005

In accordance with efforts to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA), Medi-Cal is planning to discontinue acceptance of proprietary and non-HIPAA standard electronic formats for electronic claim transactions. The first provider community to be affected is the Inpatient provider community.

Beginning **December 1, 2005,** proprietary and non-HIPAA standard electronic claim formats submitted by Inpatient providers will no longer be accepted.

Please see **Inpatient Provider Cut-off Date**, *page 6*

Inpatient Provider Cut-off Date *(continued)*

Self-Service HIPAA Transaction Utility Tool

A self-service environment, HIPAA Transaction Utility Tool, will soon be available for submitters. Initially, the utility tool will be available only for inpatient submitters to validate ASC X12N 837 v.4010A1 transactions in preparation for proprietary format discontinuance. However, the utility tool will become available to other submitter communities as their timeline for proprietary format discontinuance is determined.

The utility tool will offer transaction validation (inclusive of Companion Guide-level editing), troubleshooting and reporting features that enhance, but do not replace, Medi-Cal's current testing and media activation requirements. Inpatient submitters have been notified of the utility tool's availability via e-mail or letter depending on information availability.

Providers may call the Telephone Service Center (TSC) at 1-800-541-5555 for more information.

Cutoff dates for non-HIPAA standard claim formats for all other provider communities will be announced in upcoming *Medi-Cal Updates*.

Instructions for Manual Replacement Pages — Part 2

November 2005

Pharmacy Bulletin 618

Remove and replace:	dura bil dme 1/2 *
Remove:	dura bil dme 19/20
Insert:	dura bil dme 19 thru 22 *(new)*

DRUG USE REVIEW (DUR) MANUAL

Remove from the *Education* section:	36-21
Insert:	36-21 thru 25 * *(new)*

* Pages updated due to ongoing provider manual revisions.